

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0050978

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

12462

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. Primary Registration District No. Registrar's No.

VS 300
Rev. 4/59

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USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH JAF 11-130 64		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b LIFE	
c. FULL NAME OF (If, not in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last HENRY G. BURGETTE		4. DATE OF DEATH Month Day Year DECEMBER 13, 1963	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/9/94
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEMAN		10b. KIND OF BUSINESS OR INDUSTRY PVT. FAMILY	
11. BIRTHPLACE (City and state or country) ST. MARYS, MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME GUSTUS BURGETTE		13b. MOTHER'S MAIDEN NAME JOSEPHINE (UNKNOWN)	
14. NAME OF HUSBAND OR WIFE ETHEL BURGETTE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Crystal City, Mo. CHARLES BURGETTE, 228 County Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2nd + 3rd Degree Burns of body (90%) suffered in fire in home on or about December 10th 1963. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) accident 9/60-16			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) See above	
20c. TIME OF INJURY Hour a.m. p.m. 12-10-63	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 06	20f. CITY, TOWN, OR LOCATION St. Louis, Mo.
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Deputy Registrar		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 12-17-63		23. NAME OF CEMETERY OR CREMATORY National Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12/18/63	
23c. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.		23d. DATE RECD. BY LOCAL REG. DEC 17 1963	
23e. FUNERAL DIRECTOR CHARLES J. GATES, JR., 4107 Finney		23f. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body, whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Rayton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.